Targeted Consultation Intake Form

This form allows me to prepare your Targeted Consultation in order to offer 2 to 3 recommendations adapted to your daily life. The information collected is strictly confidential and stored securely. **Please complete this form carefully and return it by email no later than the day before your appointment.**

1. Your main priority

What is the main reason you booked this Targeted Consultation ?

2. Dietary habits

Do you follow a particular diet or nutrition program? ☐ Yes ☐ No

If yes, which one?

____

Do you have any food allergies or intolerances? ☐Yes ☐No

If yes, which ones?

____

Among the following options, check those that correspond to a habit (3 times per week or more):

☐ I eat quickly
☐ I eat while doing something else (screen, work, etc.)
☐ I skip a meal despite being hungry
☐ I eat even if I'm not hungry
☐ I keep eating even if I'm full
☐ I eat snacks inbetween meals
☐ I eat dinner late (at 8pm or later)
☐ I eat out (restaurant, cafeteria, etc.)
☐ I use canned, prepared, frozen foods or leftovers

3. Your current daily rhythm (very important)

☞ Please describe a recent, ordinary day that is representative of your daily life (not an exceptional day).

Date : ____________________

Quality of sleep	☐Light ☐ Broken ☐Restful ☐Excessive / difficult to wake up
Wake-up time	____________________
Time of getting up (if different from wake-up)	
Appetite on waking	☐ None ☐ Weak ☐Good ☐Intense
Breakfast time	____________________
Breakfast menu (foods and drinks)	
Sensations after breakfast (e.g.: light / satisfied/ heavy / bloating / drowsiness / discomfort / mental clarity or brain fog)	
Morning activities and snacks	
Appetite before lunch	None Weak Good Intense
Lunch time	____________________
Lunch menu (foods and drinks)	
Sensations after lunch (e.g.: light / satisfied/ heavy / bloating / drowsiness / discomfort / mental clarity or brain fog)	
Afternoon activities and snacks	
Appetite before dinner	None Weak Good Intense
Dinner time	____________________
Dinner menu (foods and drinks)	
Sensations after dinner (e.g.: light / satisfied/ heavy / bloating / drowsiness / discomfort / mental clarity or brain fog)	
Evening activities and snacks	
Bedtime	____________________
Time of falling asleep (if different)	
Bowel movement time(s) (if applicable)	
Emotions / general mood during the day	

Is this day representative of your usual routine?

☐ Yes ☐ Partly ☐ No

If not or partly, how is it different? ____________________________________

4. Additional information

Your general energy level lately:

☐ Stable et sufficient

☐ Variable

☐ Frequent fatigue

☐ Exhaustion

Do you have any other important information to report (for example: current health condition, medications affecting digestion, energy, or sleep)?

5. Final declaration

*I understand that this Targeted Consultation aims to offer **a few personalised recommendations** regarding lifestyle and/or nutrition and does not constitute a full Ayurvedic consultation. **The recommendations provided do not under any circumstances replace medical advice, medical supervision, prescribed treatment, or medical care.***

I confirm that the information provided is accurate to the best of my knowledge and agree to receive the recommendations offered within this framework.

I understand that the information shared is confidential and used only within the context of this service.

Date : ____________________

Client signature: ____

Reserved to the practitioner

General observations

Vikrti potentielle : ____

Prakrti potentielle : ____

Dhatus potentiellement atteints : ___________________________________

Srotamsi potentiellement atteints : __________________________________